STATE OF NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

SUMMARY PROGRAM DESCRIPTION

FOR EMPLOYEES AND RETIREES

Department of the Treasury
Division of Pensions and Benefits

January 2003

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Table of Contents

INTRODUCTION

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the State Health Benefits Program (SHBP). The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance and the Commissioner of the Department of Personnel or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

State law and the New Jersey Administrative Code govern the SHBP. Although every effort has been made to ensure the accuracy of this *Summary Program Description*, if there are discrepancies between the information presented here in this handbook or the law or regulations, the latter will govern.

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send e-mail to: *pensions_nj@tre.state.nj.us*

OPEN ENROLLMENT

ACTIVE EMPLOYEES

The SHBP holds its annual Open Enrollment period each fall for all eligible State employees and local participating employees. Specific dates for the Open Enrollment period are announced in advance by the SHBP. Coverage changes made during the Open Enrollment period will be effective the first biweekly payroll period of the new plan year for State employees paid through the State's Centralized Payroll Unit, and January 1 of the following year for all other State and local employees. Completed applications must be returned to your human resources representative or payroll officer by the deadline indicated in the Open Enrollment announcement materials.

The annual Open Enrollment period is your opportunity to make changes to the coverage provided to you and your dependents. During the Open Enrollment period, you may:

- enroll in any of the plans offered by the SHBP, if you have not previously done so;
- change to another SHBP health plan;
- enroll in, or change dental plans (State employees only);
- add dependents you have not previously enrolled; and
- delete dependents (this can also be done at any time during the year).

RETIREES

There is no specific Open Enrollment period for Retired Group members. A retiree can switch medical plans once in any 12-month period or when rates change. A retiree may also change plans if the retiree is covered under NJ PLUS or an HMO and moves into or out of the plan's service area.

For additional retiree transfer and coverage change opportunities, see the Change of Coverage section on page 46.

CHOOSING A HEALTH PLAN

Choosing a health plan is an important decision and one that requires careful consideration. Because there is no single best plan, the SHBP offers a selection of several quality health plans.

To select a health plan that meets your needs, and those of your dependents, review the information available to you in this booklet, any additional information available from the health plans, and consider the following factors:

COVERAGE

Each plan offers a variety of services. For example: some plans cover preventive and wellness services while others do not. The SHBP creates a plan comparison chart each year that provides important information to our employees and retirees. The benefit section of this chart is reproduced on pages 28 - 33. To obtain a copy of the complete chart, see your employer or call the Division's Benefit Information Library at (609) 777-1931 and enter information selection number 130. After the recorded information, you can request that a copy of the chart be mailed to you. The comparison information is also available over the Internet at: *www.state.nj.us/treasury/pensions/shbp.htm*

Additional plan information is also available by calling the plans you are interested in. Telephone numbers, addresses, and Internet addresses are found in each plan description beginning on page 13.

CHOICE OF PROVIDER

The **Traditional Plan** allows you to use any licensed medical provider or hospital facility. Should you need specialist care, you may also choose to use any licensed specialist. Benefits are payable subject to deductibles and coinsurance.

The **Health Maintenance Organizations (HMOs)** offer a list of participating providers from which you may select a Primary Care Physician (PCP). That physician coordinates all your care. Unless your HMO allows open access to participating specialists, referrals must be obtained from your PCP in order for you to visit a specialist. An annual GYN visit does not require a referral. Further information can be found in each plan's summary or you may call the plan directly.

NJ PLUS is a point-of-service plan, meaning you decide which provider to use when you need a service. NJ PLUS has in-network benefits which apply when you select and use a primary care physician from the list of participating providers. As with an HMO, all care is coordinated though your PCP. Referrals must be obtained from your PCP in order for you to visit a specialist. NJ PLUS also offers out-of-network benefits that allow you to use any licensed medical provider or hospital facility. In-network benefits are provided subject to the payment of the applicable copayment. Out-of-network benefits are payable subject to a deductible and coinsurance.

How to Access Information That Can Help You Choose a Provider

To help you find a physician, or to determine that a physician you wish to use is in a certain plan, call the plan directly to request a provider directory or check the plan's Website for a listing of the participating physicians. In addition, the SHBP offers the Unified Provider Directory (UPD). Updated monthly, the UPD is available over the Internet and contains information about health care providers and facilities that deliver their services through one or more of the SHBP's managed-care plans in New Jersey and selected areas of neighboring states (for other states, contact the plan for provider information). The information is in an easy to use format so you will no longer have to search through numerous provider directories to determine if a provider participates in a plan in which you are interested. The UPD can be reached through the SHBP Internet home page at: *www.state.nj.us/treasury/pensions/shbp.htm*

CONVENIENCE

Some plans may have certain providers who are affiliated with hospitals that are more convenient to your home or workplace. It is important to consider the hospital affiliation of your selected provider as well as the location of the provider's office. This information can be obtained from the health plan, the UPD (see above), or by contacting the provider directly.

COST

Depending upon your employer's benefit policies or agreements with the labor organization (union) representing you, you may be required to pay premiums or share in the cost of your health plan. Check with your human resources representative or benefit administrator to determine if you are required to pay any portion of the cost of your health care.

The **Traditional Plan** and **NJ PLUS out-of-network** benefits require that an annual deductible be met, and services are reimbursed subject to coinsurance based on reasonable and customary allowance for the service. Therefore, when you are enrolled in the Traditional Plan or utilizing NJ PLUS out-of-network benefits, your out-of-pocket expenses may substantially increase because you will be charged for any portion of the fee that is above the reasonable and customary amount allowed for that service. For example, if a physician's charge for a surgical procedure is $500 and the reasonable and customary amount is $400, you are responsible for the $100 difference in addition to any coinsurance and deductible amounts.

HMOs and **NJ PLUS in-network** benefits require copayments for routine services such as office visits, use of emergency rooms, etc. When using an HMO or NJ PLUS in-network there is no deductible or coinsurance and reasonable and customary charges do not apply.

EMPLOYEE ASSISTANCE PROGRAMS

Employee Assistance Programs (EAP) are staffed by professional counselors who can help employees and their eligible dependents handle problems such as stress, alcoholism, drug abuse, mental health conditions, and family difficulties. An EAP will provide education, information, counseling, and individual referrals to assist with a wide range of personal or social problems. The EAP will also assist you in obtaining a referral to the proper health care provider, and help in day-to-day communications with your health plan.

An employee's contact with this service is private, privileged, and strictly confidential. No information will be shared with anyone at anytime without your written consent.

The following EAP services are available to State Employees:

State Employee Advisory Service (EAS) . . . . . Active State Employees	(609) 292-8543
Rutgers University Personnel Counseling Service (EAP)	(732) 932-7539
New Jersey State Police EAP	(856) 234-5652 (908) 231-1077 (609) 633-3718 1-800-FOR-NJSP
University of Medicine and Dentistry of New Jersey EAP	(973) 972-5429

Employees of local employers may have an EAP available to them. To find out about such services you should check with your employer's human resource office.

TAX$AVE FOR STATE EMPLOYEES

Tax$ave is a benefit program available to State employees under Section 125 of the federal Internal Revenue Service Code. This voluntary program allows eligible employees to set aside before tax dollars to pay for certain medical, dental, and dependent care expenses, thereby avoiding federal taxes and saving money. Tax$ave consists of three components:

— The **Premium Option Plan** (POP) allows employees to pay any State Health Benefits Program medical and/or dental premiums they may have with before tax dollars.

— The **Unreimbursed Medical Spending Account Plan** (UMSA) allows employees to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which they or their dependents are covered.

— The **Dependent Care Spending Account Plan** (DCSA) allows an employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

You may join Tax$ave or make changes to your Tax$ave plan during the Tax$ave Open Enrollment period. Call Horizon Healthcare Insurance Agency at 1-800-224-4426 for more information.

PRESCRIPTION DRUG BENEFITS

EMPLOYEE PRESCRIPTION DRUG PLAN

The Employee Prescription Drug Plan is offered to active State employees and their eligible dependents as a separate drug plan. Local employers may also elect to provide the SHBP Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through AdvancePCS.

Plan Benefits

For each 30-day supply obtained at a retail pharmacy, participants pay a $1 copayment for **generic** drugs and a $5 copayment for **brand name** drugs. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

A mail order program is also available. When mail order is used, up to a 90-day supply of medication has a $1 copayment for **generic** drugs and a $5 copayment for **brand name** drugs.

The State Health Benefits Commission has required that all participating employees and retirees have access to prescription drug coverage. If you are employed by a county, municipality, board of education, or other local public employer who does not provide a separate prescription drug plan, medical plans offered through the SHBP will include prescription drug benefits.

If you are eligible for prescription drug coverage through a separate drug plan provided by your employer, your SHBP medical plan will not include prescription drug coverage and any prescription drug copayments from other group plans are not reimbursable through the Traditional Plan, NJ PLUS, or any SHBP HMO.

Traditional Plan and NJ PLUS

Active employees whose employer does not offer a separate prescription drug plan have prescription drug coverage through the Traditional Plan and NJ PLUS. By presenting a discount prescription card to the pharmacist, members are charged a reduced fee and the claim is electronically submitted to the plan for consideration. See the plan descriptions for specific details.

Participating SHBP HMOs

The SHBP HMOs provide a prescription drug card benefit for those employees whose employer does not offer a separate prescription drug plan. The plan features a three-tiered design with copayments for up to a 30-day supply of $5 for **generic** drugs (Tier I), $10 for **preferred brand name** drugs (Tier II), and $20 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy and prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you. Certain prescription drugs may require precertification prior to purchase. Please contact your HMO for details.

The purchase at a pharmacy of up to a 90-day supply of medication may also be available by paying the applicable copayments (60-day supply — two copayments, 90-day supply — three copayments). Contact your HMO for more information.

A mail order program is also available. Copayments for mail order vary depending on the HMO you select. See the plan descriptions for specific details.

RETIREE PRESCRIPTION DRUG COVERAGE

Traditional Plan and NJ PLUS

Retirees enrolled in the Traditional Plan or NJ PLUS have access to a separate prescription drug card plan that includes a mail order service. The plan features a three-tiered design. Based on the formula adopted at the time the plan was implemented, effective January 1, 2003, copayment amounts for a 30-day supply are set at $6 for **generic** drugs (Tier I), $11 for **preferred brand name** drugs (Tier II), and $23 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments).

Mail order copayments for up to a 90-day supply are $6 for **generic** drugs, $17 for **preferred brand name** drugs, and $28 for **all other brand name** drugs.

Also effective January 1, 2003, there is a $397 annual maximum in prescription drug copayments per person. Once a person has paid $397 in copayments in a calendar year, that person is no longer required to pay any prescription drug copayments for the remainder of that calendar year.

Participating SHBP HMOs

The SHBP **HMOs** provide retirees with prescription drug benefits. The plan features a three-tiered design with copayments for up to a 30-day supply of $5 for **generic** drugs (Tier I), $10 for **preferred brand name** drugs (Tier II), and $20 for **all other brand name** drugs (Tier III) when purchased at a participating retail pharmacy and prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you. Certain prescription drugs may require precertification prior to purchase. Please contact your HMO for details.

The purchase at a pharmacy of up to a 90-day supply of medication may also be available by paying the applicable copayments (31- to 60-day supply — two copayments, 61- to 90-day supply — three copayments). Contact your HMO for more information.

A mail order program is also available. Copayments for mail order vary depending on the HMO you select. See the plan descriptions for specific details.

RECENT BENEFIT CHANGES

GENERAL CHANGES

Pap Smears

Effective August 27, 2001, charges involving a routine screening Pap smear are covered (after any deductible, copayment, and/or coinsurance) as ordered by the woman's physician, including the office visit, laboratory costs associated with a Pap smear, and any necessary confirmatory tests.

Treatment of Infertility

All SHBP medical plans provide coverage for medically necessary expenses incurred in the diagnosis and treatment of infertility. Usual plan copayments, deductibles, and coinsurance provisions apply.

Notice of Provider Termination

Any person enrolled in a managed care plan (HMO or NJ PLUS) must be provided with 90-days notice if that person's Primary Care Physician (PCP) will be terminated from the provider network. If 90-day notice cannot be provided, the managed care plan must notify the member as soon as possible. The covered person may then choose another PCP or may change coverage to another participating health benefits plan.

Qualified Medical Child Support Orders (QMCSO)

If a QMCSO is issued for your child, the child will be eligible for coverage, and that parent's plan will be the primary plan for that child. The employer must be notified and an application submitted electing coverage for the child within 60-days of the date the order was issued.

Temporary Voluntary Furlough "Rule Relaxation" (State Employees Only)

Effective April 30, 2002 the Department of Personnel Merit System Board issued a "rule relaxation" extending through June 30, 2003. During this period, a State employee can take unlimited furlough, if approved by their employer, without loss of employer paid health benefits. As of July 1, 2003 the "rule relaxation" will cease and health benefits will only be covered for up to 30 days of furlough (Chapter 297, P.L. 1993).

Aggregate of Service Credit

Upon retirement, a State employee, or a board of education or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP. An employee of a local government who has 25 years or more of service credit whose employer is enrolled in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP. Effective August 15, 2001, instead of having to meet the 25-year service credit requirement from a **single** State or locally-administered retirement system, a retiree under the SHBP may receive this benefit if the 25 years of service credit is from one or more State or locally-administered retirement systems and nonconcurrent.

Waiver of Coverage

A municipal authority participating in the SHBP may allow an employee covered as a dependent by a spouse's employer to waive SHBP health benefits coverage and be reimbursed up to 50% of the amount saved by the authority. Coverage may be resumed if the spouse's dependent coverage is no longer in effect. The decision of a municipal authority to allow its employees to waive coverage and the amount of consideration to be paid are not subject to collective bargaining.

TRADITIONAL PLAN AND NJ PLUS CHANGES

Chiropractic Care Benefit

Effective January 1, 2002, both the Traditional Plan and NJ PLUS cover a maximum 30 visits, per person, per calendar year. Medical records and treatment plans no longer need be submitted. Usual plan copayments, deductibles, and coinsurance provisions apply.

In-Network Facility Coverage (NJ PLUS)

Effective January 1, 2003, all in-network facility medically necessary health care expenses will be reimbursed at the carrier's full contractual rate without penalty whether the member has selected a treating practitioner that is an in-network or out-of-network provider. Previously if an out-of-network provider admitted the patient to an in-network facility the expenses were paid at the out-of-network level. This resulted in significant out-of-pocket expenses due to the application of deductibles, coinsurance and charges that exceeded the facilities contractual allowance.

The new provision will only apply if the patient complies with all NJ PLUS pre-authorization and review requirements in place to determine the medical necessity of an in-patient confinement. The in-network contractual rate paid by NJ PLUS represents payment in full to the facility. The facility may not balance bill the patient for any remaining balances involving medically necessary expenses.

Retiree Prescription Drug Card Program

Retirees enrolled in the Traditional Plan or NJ PLUS have access to a separate prescription drug card plan that includes a mail order service. The plan features a three-tiered copayment design. Based on the formula adopted at the time the plan was implemented, effective January 1, 2003, copayment amounts for a 30-day supply are set at $6 for generic drugs (Tier I), $11 for preferred brand name drugs (Tier II), and $23 for all other brand name drugs (Tier III) when purchased at a participating retail pharmacy. Mail order copayments are set at $6 for generic drugs, $17 for preferred brand name drugs, and $28 for all other brand name drugs for up to a 90-day supply. Also effective January 1, 2003, the annual maximum copayment for prescription drugs is $397 per person. Once a person has paid $397 in copayments in a calendar year, that person is no longer required to pay any prescription drug copayments for the remainder of that calendar year.

HMO CHANGES

University Health Plans HMO Terminates with SHBP

As of August 1, 2002, University Health Plans HMO terminated participation with the SHBP.

Aetna Name Change

Aetna Health is the new corporate name for the former Aetna US Healthcare HMO.

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

Health plan telephone numbers and mailing addresses are located in the individual plan descriptions beginning on page 13.

ADDRESSES

Our Mailing Address is . . . . . The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is . . . . . *www.state.nj.us/treasury/pensions/shbp.htm*

Our E-mail Address is . . . . . *pensions_nj@tre.state.nj.us*

TELEPHONE NUMBERS

Division of Pensions and Benefits:

Benefit Information Library/Fax on Demand	(609) 777-1931
Office of Client Services	(609) 292-7524
TDD Phone (Hearing Impaired)	(609) 292-7718
State Employee Advisory Service (EAS)	(609) 292-8543
Rutgers University Personnel Counseling Service (EAP)	(732) 932-7539
New Jersey State Police	
Employee Advisory Program (EAP)	(856) 234-5652
	(908) 231-1077
	(609) 633-3718
	1-800-FOR-NJSP
University of Medicine an Dentistry of New Jersey (EAP)	(973) 972-5429
New Jersey Department of Banking and Insurance	
Individual Health Coverage Program Board	1-800-838-0935
Consumer Assistance for Health Insurance	(609) 292-5316 (Press 2)
New Jersey Department of Human Services	
Pharmaceutical Assistance to the Aged and Disabled (PAAD)	1-800-792-9745
New Jersey Department of Health and Senior Services	
Division on Senior Affairs	1-800-792-8820
Insurance Counseling	1-800-792-8820
Independent Health Care Appeals Program	(609) 633-0660
Centers for Medicare and Medicaid Services	1-800-Medicare
New Jersey Medicare - Part A	1-866-641-2007
New Jersey Medicare - Part B	1-800-462-9306

SHBP RELATED PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects. Employees and retirees can obtain copies of these publications by contacting their employers or by calling the Division of Pensions and Benefits. Our Benefit Information Library (BIL) is available 24 hours-a-day, seven days-a-week. If the items you require have a BIL number, dial (609) 777-1931, from a touch-tone phone, and enter the three-digit BIL selection number when instructed. After the recorded information leave your name, mailing address with ZIP Code, and Social Security number to have the publication or fact sheet mailed to you.

If the items you require have a Fax on Demand (FOD) number, you can have the publication or fact sheet automatically faxed to your fax machine. To use our Fax on Demand service, dial (609) 777-1931. Follow the instructions to access Fax on Demand and, when requested, enter the four-digit FOD selection number along with your fax number (area code and telephone).

Fact sheets and other publications are also available for viewing or downloading over the Internet at: *www.state.nj.us/treasury/pensions*

General Publications

State Health Benefits Program Comparison Summary - Plan comparison chart. (BIL #130)

Benefit Information Library Catalog - A catalog of informational items available through the Benefit Information Library and Fax on Demand service. (FOD #8000)

SHBP Fact Sheets

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire.* (BIL #208) (FOD #8208)

Fact Sheet #23, *The State Health Benefits Program and Medicare Parts A & B for Retirees.* (BIL #134) (FOD #8134)

Fact Sheet #25, *Employer Responsibilities under COBRA.* (BIL #345) (FOD #8345)

Fact Sheet #26, *Health Benefits Options upon Termination of Employment.* (BIL #258) (FOD #8258)

Fact Sheet #30, *The Continuation of New Jersey State Health Benefits Program Coverage Under COBRA.* (BIL #254) (FOD #8254)

Fact Sheet #47, *SHBP Retired Coverage Under Chapter 330 - PFRS & LEO.* (BIL #136) (FOD #8136)

Fact Sheet #51, *Continuing SHBP Coverage for Overage Children with Disabilities.* (BIL #259) (FOD #8259)

SHBP Health Plan Member Handbooks and Other Resources

SHBP NJ PLUS Member Handbook

SHBP Traditional Plan Member Handbook

SHBP HMO member handbooks are available from the individual HMOs.

NJ HMO Performance Report (see page 12).

2001 New Jersey HMO Performance Report: Compare Your Choices.

You can compare quality ratings of various HMO's with the New Jersey Department of Health and Senior Services' 2001 *New Jersey HMO Performance Report: Compare Your Choices.* A summary of selected report data, as it relates to HMOs in the SHBP, is provided in the chart below.

From the health plans that seem to best fit your needs, check the issues that are most important to you and your family. For example, if you have a young child, you might be most interested in the performance measures in the Care for Kids section of the report. Be careful, however, not to make decisions based on small differences that are not meaningful. Look at all factors that contribute to a health plan's performance, not just results for a single measure.

To obtain a complete copy of the 2001 *New Jersey HMO Performance Report: Compare Your Choices,* contact the New Jersey Department of Health and Senior Services, Office of Managed-Care, PO Box 360, Trenton, NJ 08625-0360, or call 1-800-418-1397. The report is also available over the Internet at: *www.state.nj.us/health*

To get additional information from the health plans you are most interested in joining, see the following Plan Description Pages.

COMPARISON OF HEALTH MAINTENANCE ORGANIZATIONS BASED ON DEPARTMENT OF HEALTH AND SENIOR SERVICES — 2001 NJ HMO PERFORMANCE REPORT

PLAN NAME	OVERALL PERFORMANCE			
	SERVICE AND ACCESS	DOCTORS AND MEDICAL CARE	STAYING HEALTHY	GETTING BETTER/LIVING WITH ILLNESS
Aetna	●	●	●	●
AmeriHealth	●	●	●	◓
CIGNA HealthCare	◓	○	●	◓
Health Net	◓	◓	◓	○
Horizon HMO (see note)	◓	◓	◓	◓
Oxford Health Plan	◓	◓	●	●

Performance Compared to the Average

- ● **Higher** than the New Jersey health plan average
- ◓ **About the Same** as the New Jersey health plan average
- ○ **Lower** than the New Jersey health plan average

Note: Horizon HMO is no longer in the SHBP, however, the provider network is the same as **NJ PLUS in-network.**

For rating details see the *2001 New Jersey HMO Performance Report: Compare Your Choices*.

PLAN DESCRIPTIONS

The information on the following plan description pages is supplied by each individual health plan and intended to provide a brief overview of the plan and the benefits it offers. If there are discrepancies between the information presented in these pages and the law, regulations, or contracts, the latter will govern. If you have questions or concerns about the information presented please write to the State Health Benefits Program, Division of Pensions and Benefits, PO Box 299, Trenton, NJ 08625-0299.

Certain prescription drugs may require precertification prior to purchase. Please contact your health plan for details.

Turning Promise into Practice™

You can enjoy all the benefits of an Aetna HMO or Elect Choice Plan such as: routine checkups; hospitalization and surgery; Emergency Care - anytime, anywhere; specialty care; diagnostic testing; vision services.

Network Access - When it comes to health care, nothing may be more important to our members than having access to quality doctors and hospitals. Members in Connecticut, Delaware, New Jersey, Pennsylvania; and parts of Arizona, Florida, Illinois, Indiana, Maryland, New York, North Carolina, Texas, and Virginia can access our networks of quality providers.

Aetna's HMO for Active Employees and Early Retirees; Elect Choice™ for Medicare Eligible Retirees - Both plans offer quality coverage with the added benefit of *low out-of-pocket costs.* There are no claim forms to fill out and no deductibles to pay. Each covered member of your family must select a participating Primary Care Physician (PCP) to coordinate their care. The PCP may be either an internist, family doctor, pediatrician, or general practitioner. You may change your PCP selection at any time by calling member services or via Aetna Navigator. PCPs provide routine care for illness, injury and preventive care such as periodic physical examinations, eye exams, well-baby visits and immunizations. Members are responsible for a copayment for each visit.

Medicare Eligible Retirees enrolled in Aetna and their dependents who are eligible for Medicare will be enrolled in Aetna Life Insurance Company's Elect Choice Plan. They will have the same benefits, the same copayments, and with a few exceptions, the same providers as those enrolled in the HMO plan, but Medicare will be the primary payer. Retirees enrolled in this plan will receive an identification card that indicates they are in the ***Elect Choice Plan.*** You should present your Medicare identification card and your Elect Choice card when receiving medical services.

Electronic Referrals - Your PCP may refer you to a network **specialist** as part of your treatment plan. Under both plans you will need to obtain a referral from your PCP to visit the specialist and you will be responsible for a set copayment for each referred visit. **Electronic referrals** are available in some PCP offices. Where available, the PCP's office can electronically transmit your referral to participating specialists. This eliminates the need to pick up a written referral once your PCP has authorized specialty care. Check with your PCP to inquire if they have the ability to use electronic referrals.

Open Access Gynecology Program - Female members have **direct access** (no referral needed) to participating **obstetricians/gynecologists** (ob/gyn). Members are covered for routine well-woman exams, including a Pap smear, gynecological-related problems, follow-up care, and obstetrical care.

Emergency Care - If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Members who are traveling outside their HMO service area or students who are away at school are covered for emergency and urgently needed care.

Aetna Navigator™ - A powerful web-based tool designed to help you access and navigate a wide range of health information and programs. Navigator provides a single source for online benefits and health-related information. As an enrolled Aetna member you can register for a secure, personalized view of your Aetna benefits 24 hours a day, 7 days a week wherever you have Internet access. Navigator allows you to request member ID cards, review plan coverage details, review claim status, and EOBs (explanation of benefits) and more. To register, go to *www.aetna.com.*

DocFind® - It's *easy* to choose a Primary Care Physician (PCP), search for participating physicians, hospitals and other health care providers from our extensive network via the internet. You can select a provider based on geographic location, medical specialty, hospital affiliation, and/or languages spoken. In addition you can obtain maps, driving directions, and physician perform-

ance summaries. DocFind is updated three times a week, giving you access to the most up-to-date list of participating providers. To use DocFind, simply go to *www.aetna.com.* If you need a paper directory, call the Member Services number on the back of your ID card.

Cancer Screening Programs - Routine cancer screenings are covered for age eligible members. Refer to your plan documents for coverage information including copayments and limitations.

Prescription Drug Coverage - Outpatient prescription drugs, including insulin, are covered. Each prescription is limited to a maximum 30-day retail supply, with up to five refills when authorized. There is a copayment per 30-day prescription or per refill of $5 for covered generic drugs, $10 for covered preferred brand name drugs, and $20 for all other covered brand name drugs. A mail order pharmacy program is also available to obtain up to a maximum 90-day supply of covered medications. Mail order copays are $5 / $15 / $25 for the same three categories of drugs described above. All prescription drugs are not covered under the plan. Refer to your plan documents and the formulary guide to determine limitations and exclusions under the plan. You may also call Member Services or log on to our website to inquire about coverage of a particular drug prior to enrollment. (Prescription coverage through Aetna may not be applicable to all employees).

Vision One® - You are eligible to receive substantial discounts on eyeglasses, contact lenses, and nonprescription items such as sunglasses and contact lens solutions through the Vision One Program at more than 2,500 locations across the country. The program also includes a discount on Lasik surgery. For more details about the Vision One Program from Cole Vision and to receive a listing of Vision One stores in your area, call 1-800-793-8616 weekdays 9:00 a.m. - 9:00 p.m., Saturdays 9:00 a.m. - 5:00 p.m. EST.

Member Health Information - The *Informed Health® Line* provides members with a toll free line to registered nurses experienced in providing information on a variety of health topics. This service is available 24 hours a day, 7 days a week.

Alternative Health Care Programs - This program offers access to alternative therapies and products to our members. Call Member Services for information.

- **Natural Alternatives** services available at reduced rates.
  - — Acupuncture therapy
  - — Chiropractic manipulation
  - — Massage therapy
  - — Nutritional counseling
- **Vitamin Advantage™ -** you can save on the purchase of over-the-counter vitamins and nutritional supplements.
- **Natural Products -** this program provides savings on many health-related products.

Women's Health for Life Programs - Aetna is committed to providing a variety of services and education emphasizing issues and concerns shared by women though all stages of their life. We include programs in our HMO plan that support women's unique health care needs. See our website for more information *www.aetna.com.*

Active Employees and Early-Retirees can contact Member Services at 1-800-309-2386.
Retirees with Medicare can contact Member Services at 1-800-345-4432.
Customer Service Representatives are available weekdays to answer your questions 8 a.m. to 6 p.m. EST Monday to Friday.

You may also access our Web site at *www.aetna.com*

AmeriHealth HMO

AmeriHealth HMO, Inc. and its affiliate companies serve more than 4 million members. By drawing on more than 60 years of experience, AmeriHealth HMO and its affiliates have the knowledge and resources to deliver quality heath care coverage. We strive to continually enhance our programs, technology, and customer service in an effort to find new ways to meet member needs.

Network

AmeriHealth HMO offers one of the largest provider networks with nearly 9,000 primary care physicians, more than 36,000 specialists, and 200 hospitals. Our provider network spans the entire States of New Jersey and Delaware, and Southeastern Pennsylvania. Our network includes providers from many medical fields. In addition, HMO members have nationwide access to care through the largest network of HMOs in the country. Across the country and around the world, our members have peace of mind when they carry our card because of the comprehensive coverage we provide.

Quality

AmeriHealth HMO is committed to quality care for our members, so we carefully review providers before inviting them into our network. We believe that the care and coverage that we offer is high quality. Both state and national organizations have recognized AmeriHealth HMO for excellence in our programs and services. For the fifth consecutive year, in the State of New Jersey *HMO Performance Report: Compare Your Choices,* AmeriHealth HMO performed above the state average. AmeriHealth HMO earned top scores in the categories of Service and Access, Doctors and Medical Care, and Staying Healthy/Avoiding Illness. AmeriHealth HMO was ranked #1 in Ability to Obtain Care Quickly, Testing for Breast Cancer, and Providing Immunizations to Children. In addition, AmeriHealth has earned an "excellent" status from the National Committee for Quality Assurance (NCQA).

Core Benefits and Special Services

AmeriHealth HMO covers doctor visits, specialty care, hospital services, and out-of-area coverage. Most visits are covered 100 percent with just a $5 copayment. Our benefits include full preventive care services including periodic health assessments, immunizations, routine gynecological care, and well baby/well child care. AmeriHealth HMO covers most prescription drugs with a retail pharmacy copayment of $5 for (formulary) generic drugs, $10 for (formulary) preferred brand name drugs, and $20 for all other (non-formulary) brand name drugs. A 90-day supply is also available by mail order with a copayment of $5 for (formulary) generic drugs, $15 for (formulary) preferred brand name drugs, and $25 for all other (non-formulary) brand name drugs. More than 53,000 pharmacies nationwide participate in the pharmacy network, including independent pharmacies and local and national chains. And members do not have to pre-select one pharmacy. We also offer a preventive pediatric dental program for children under age 12.

AmeriHealth Healthy Lifestyles℠ Wellness Program

AmeriHealth HMO offers the AmeriHealth Healthy Lifestyles℠ wellness programs for each stage of your family's life. There is no other health insurer in the area that offers all the comprehensive, value added wellness programs that AmeriHealth offers as part of our managed care plans. The discounts, reimbursements and special incentives available through our AmeriHealth Healthy Lifestyles programs can provide extra value to your health care coverage. We have recently refined these programs to make them more accessible and easy to use. The AmeriHealth Healthy Lifestyles programs consist of four portfolios including Health Management, Women's Health, Alternative Health and Family Health. AmeriHealth HMO welcomes inquiries from prospective members Monday through Friday, 8:30 a.m. to 5:00 p.m.

Connections Health Management Programs

These programs are designed to help members with chronic conditions improve their health and the overall quality of their lives. Enrollment in Connections is easy and voluntary. If you have a chronic condition, talk to your Primary Care Physician or family doctor about how Connections can help you. Available programs include asthma, diabetes, congestive heart failure, cardiac, and total joint replacement.

Baby FootSteps

Our maternity program helps identify possible risk factors during pregnancy. It also offers educational materials and up to $40 back for the cost of any childbirth class.

Pediatric Immunization

To help parents ensure their children are fully vaccinated by age two, we send special mailings to parents with a recommended schedule of immunizations. Answers to commonly asked questions and concerns are also included.

www.amerihealth.com and www.amerihealthexpress.com

Visit us online where we offer a variety of educational resources and more than 1,200 health and wellness products, featuring preferred discounts and free shipping. www.amerihealthexpress.com makes it easy to manage your health care. You can view account information, check your benefits, find a network physician, print out forms, request an ID card, and check on claims.

For Additional Information

Mail

AmeriHealth HMO, Inc.
8000 Midlantic Drive
Suite 333
Mt. Laurel, NJ 08054

or

AmeriHealth HMO, Inc.
485 Route 1 South
3rd Floor, Building C
Iselin, NJ 08830

Telephone 1-800-877-9829

Internet www.amerihealth.com

This overview is intended to highlight the benefits available. For complete descriptions, including all benefits and exclusions, refer to the AmeriHealth HMO benefit booklet.

CIGNA HealthCare

The National Committee for Quality Assurance has awarded CIGNA HealthCare of New Jersey and CIGNA HealthCare of New York a three-year Full Accreditation.

HERE ARE THE MAIN FEATURES OF YOUR PLAN:

Carefully Chosen Physicians

Before a physician is admitted to our network, your local CIGNA HealthCare health plan thoroughly reviews his or her education, practice history and other credentials. We have similar review procedures for hospitals and other providers.

Carefully Designed Networks

Our quality standards also specify easy access to our participating doctors and hospitals. Our service area includes participating providers in New Jersey, New York, Philadelphia, Delaware and Connecticut representing over 10,000 primary care physicians and over 23,500 specialists.

Emergency Coverage

No matter where you travel in the U.S. or worldwide, you are covered for emergency care.

Direct Access for Obstetrical and Gynecological Services

Women are allowed direct access to a qualified participating provider for obstetrical and gynecological services covered by this plan. This means that you are not required to obtain authorization from your Primary Care Physician for visits to the participating provider of your choice for pregnancy and preventative gynecological conditions.

CIGNA HealthCare Healthy Babies®

A prenatal care program that includes education for mothers-to-be as well as screening and special care for high-risk pregnancies.

The CIGNA HealthCare Well Aware Program for Better Health℠

The Well Aware program provides valuable self-care tools and educational materials that support a carefully monitored physician care program for chronic conditions like low back pain, asthma, diabetes, and cardiac.

The CIGNA LIFESOURCE Organ Transplant Network®

A program that provides transplant recipients with access to the nation's leading transplant centers.

The CIGNA HealthCare 24-Hour Health Information Line℠

A specially-trained team of registered nurses is available 24 hours a day, 365 days a year. They're available to provide valuable health information and self-care advice. In situations regarding urgent or emergency care, they also help with authorizations required by your plan. You can also use our Health Information Library to hear pre-recorded programs on hundreds of health and medical topics.

Prescription Drugs

Prescriptions and refills covered up to 30-day supply when purchased at a participating pharmacy. Coverage is provided for generic and brand name drugs as prescribed by your doctor. Coverage is provided for diabetic drugs and supplies and includes insulin, insulin syringes and needles, glucose test

strips and lancets. Prenatal vitamins are also covered. Coverage is provided for contraceptive devices and oral fertility drugs.

Retail Pharmacy

Per prescription 30-day supply

Generic	$5
Preferred Brand	$10
All Other Brands	$20

(Prescription coverage through CIGNA may not be applicable to all employees.)

Vision Care

To obtain vision care services, please call Vision Service Plan toll-free at 1-800-622-7444
Exam: $5 per visit; once every 12 months.
Hardware: not covered

Take Charge of Your Health

If you have asthma, low back pain, diabetes, or need cardiac care, we offer the CIGNA HealthCare Well Aware Program for Better Health that may interest you. The innovative Well Aware programs are designed to help you better manage your condition and improve your quality of life.

If you would like more information about the Well Aware program, call Member Services at the number on your CIGNA HealthCare ID card.

Visit us Online

Isn't it time you stopped by for a visit? We think you'll be pleased by the services that are available to you on our Web site. By visiting us at *www.cigna.com*, you can:

— Change your Primary Care Physician.

— Find doctors, hospitals, dentists and pharmacies in your area that are in the CIGNA HealthCare network and download a personalized provider directory.

— Find out if a doctor is accepting new patients.

— If you have pharmacy benefits through CIGNA HealthCare, you can order your refills through our mail-order pharmacy.

We want to make it as easy as possible for you to use your health plan. So visit us soon and take advantage of these convenient online services.

QUESTIONS?

If you'd like more information about CIGNA HealthCare or how we serve your community, just call Member Services at 1-800-CIGNA24 (1-800-244-6224) between 8:00 am and 6:00 pm.

To learn more about CIGNA, or to e-mail us anytime you have a question, visit us at **www.cigna.com/healthcare.**

CIGNA HEALTHCARE
200 Regency Executive Park
Charlotte, North Carolina 28217

Choice. No Referrals/Open Access. Preventive care. Consider Health Net. We've got what you want!

At Health Net we believe the best thing for your good health is something called *respect.* We believe a member is a person, not a number or a file folder. We believe that courtesy and responsiveness count. And we believe that you should always have a significant say in your care. In other words, at Health Net, ***you matter!***

Here's how we show that ***you matter***:

No referrals needed/Open Access HMO: Who knows best when you need specialty care? We think you (and your doctor) do. That's why we give you open access to participating specialists. Open access means that you're able to see a participating specialist without a referral for a nominal copayment. Health Net is the only HMO in the State Health Benefits Program that gives you open access to participating specialists. Also, there are no claim forms to fill out and no deductibles.

Choice of participating physicians/providers: If a large choice of physicians and providers is important to you, consider Health Net. At more than 82,000 physician and provider locations in the quad-state area of New Jersey, New York, Pennsylvania, and Connecticut, including more than 24,000 provider office locations in New Jersey alone. There is a nominal copayment for office visits with participating physicians and providers.

Access to alternative medical treatments: More than 30 million Americans receive some form of alternative medical care every year. With our Health Net AlternaCare℠ program, you'll have benefits for chiropractic care and acupuncture, and discounts on massage therapy.

Convenient, toll-free customer service: We are available to answer your health benefit questions Monday through Friday, 8 a.m. to 6 p.m. or you may email your questions to us at: *member@ne.health.net.* Our service representatives can help you to select a participating physician or provider, answer your claim questions, and much more.

Smart Start℠: This reminder program helps parents keep track of their children's immunizations from birth to two years of age.

Preventive care to help you stay healthy: We provide coverage for adult and child well exams, childhood immunizations, regular eye exams and cancer screenings. Plus, our female members

are covered for regular gynecological visits.

Prescription Drug Coverage: A 30-day supply is available at participating pharmacies for a copayment of $5 for generic drugs, $10 for preferred brand name drugs with no generic equivalent, or $20 for all other brand name drugs. Up to a 90-day supply is available through mail order (call 1-800-441-5741 for details). **Note:** Prescription drug coverage does not apply to those individuals who have coverage through another program offered by their employer.

Discounted contact lenses: Through TruVision™, you'll receive up to a 50 percent savings for doctor-prescribed contact lenses and supplies. Also, they are delivered to your home at no extra shipping or handling costs.

Savings on laser vision correction: You may save significantly on high-quality laser eye surgery through an arrangement with TLC Laser Eye centers.*

*Health Net does not credential the surgeons involved or pay for the procedure.

Fitness Center discount program: Members save money at fitness centers through a health club network. You'll have discounted monthly fees and unlimited access to your primary fitness facility, plus guest privileges at other clubs.

Talk to a nurse 24 hours a day: The convenient, free Personal Health Advisor® line helps you get answers to your health and medical questions when your doctor isn't available. The Personal Health Advisor® line is a toll-free call away, 24 hours a day, seven days a week.

At Health Net, ***you matter.*** That's why more than 1 million members in the quad-state area count on us for quality health coverage for themselves and their families.

To learn more, or to see if your doctor is part of our extensive network, check out our Web site at **www.health.net**. We look forward to providing you with superior benefits and welcome your inquiries about our plan.

Health Net
3501 State Highway 66
Neptune, New Jersey 07754
1-800-441-5741

In New Jersey, coverage for the HMO is provided by Health Net of New Jersey, Inc.

NJ PLUS

NJ PLUS is a point-of-service (POS) plan administered by Horizon Blue Cross Blue Shield of New Jersey. NJ PLUS provides you the best of both worlds: in-network care similar to an HMO plan and out-of-network care similar to a traditional plan. Members that wish to use the in-network level of coverage may select from over 60,000 participating providers and more than 300 participating hospitals in a service area covering all of New Jersey, North Carolina, South Carolina, and Delaware, as well as numerous counties in Pennsylvania and New York. Members that wish to use the out-of-network level of coverage, have the freedom to access any eligible provider or hospital of their choice in an unrestricted service area. All providers participating in the NJ PLUS network are carefully selected and screened and must meet rigorous professional standards. Periodically, we review the credentials of participating providers and profile their performance to ensure that members receive the best medical care available.

In-Network Coverage

Upon enrolling, you are encouraged to select a Primary Care Physician (PCP) for yourself and eligible family members. PCPs can be located in any part of the service area and can be different for each family member. You may change your PCP simply by calling Member Services. Your PCP will provide routine care, including annual physical examinations, well-child care and immunizations with a $5 copayment per visit. If you need to see a specialist, your PCP will issue a referral to a participating provider with a $5 copayment per visit. Your PCP will also coordinate your hospital care though the NJ PLUS hospital network and you will receive 100 percent coverage.

Female members have direct access to participating Obstetricians/Gynecologists (OB/Gyns) without PCP referral. This includes an annual well-woman exam and other OB/Gyn related services. A $5 copayment applies per visit, but is waived for prenatal and postnatal maternity care visits after the initial visit.

All members have direct access to a participating optometrist or ophthalmologist for an annual vision examination with a $5 copayment. Additional visits require a PCP referral and a $5 copayment.

Out-of-Network Coverage

When you use out-of-network benefits you incur an annual deductible and coinsurance requirement of 30 percent of reasonable and customary charges. In addition, each out-of-network hospital admission requires a $200 deductible. Preventive care or well care — except immunizations for children under 12 months, mammographies, and Pap tests — is not covered at the out-of-network level.

Emergency Care

If you experience a medical emergency, please go to the nearest emergency facility immediately regardless of network status. You must contact your PCP and/or NJ PLUS within 48 hours. A $25 copayment applies if you are treated and released but is waived if you are admitted to the hospital. If you do not contact us, coverage will be at 70 percent after an annual deductible. Please note all NJ PLUS PCPs have 24-hour back up coverage in the event he/she is unavailable.

Prescription Drug Coverage

Active Local Employees -

Without a separate Prescription Drug Program

If you are an active employee and your employer does not offer a separate prescription drug plan, NJ PLUS provides a discounted prescription drug reimbursement program, when you present your discount card to the pharmacist you are charged a reduced fee for your medication and your claim is electronically submitted to the carrier for payment. NJ PLUS will reimburse 90 percent of the cost of prescriptions that are written by your network provider and 70 percent of the cost of prescriptions, less deductibles, written

by your out-of-network provider.

Prescription Drug Coverage

Retirees

Retail Pharmacy - up to 90-day supply copayment amounts

Supply	Generic	Preferred Brand	All Other Brands
01-30 days	$6	$11	$23
31-60 days	$12	$22	$46
61-90 days	$18	$33	$69

Mail Order - 90-day supply copayment amounts

Generic	Preferred Brand	All Other Brands
$6	$17	$28

Effective January 1, 2003 there is a $397 annual maximum in prescription drug copayments per person. Once a person has paid $397 in copayments in a calendar year, that person is no longer required to pay any drug copayments for the remainder of that year. Prescription drug copayments are not eligible for reimbursement and do not apply to the NJ PLUS (out-of-network) deductible.

Health and Wellness Discount Programs

Horizon BCBSNJ has established relationships with several businesses to provide various discount programs. These programs include but are not limited to the following:

SmartEyes^{SM} - discounts on eyeglasses through Cole Vision outlets. Call 1-800-424-1155.

Vision Care Advantage - discounts on laser vision correction services through Davis Vision. Call 1-877-518-8748.

Health Club Memberships - discounts at New York Sports Clubs (1-800-301-1231) and National Fitness Network (1-800-811-5454).

HEARx - discounts on hearing aids. Call 1-800-323-3277.

Healthyroads - discounts on vitamins and supplements. Call 1-877-335-2746.

Alternative Therapies - discounts on services such as yoga and massage therapy. Call 1-877-335-2746.

Precious Additions® - an education and information program for new and expectant parents.

To take advantage of these programs, simply present your NJ PLUS ID card at a participating business or mention that you are a Horizon BCBSNJ member when calling. For a complete listing and description of available discount programs,

For Additional Information

If you have questions, please call NJ PLUS Member Services at 1-800-414-SHBP (7427) during our service hours of Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also access our interactive Web-Site at **www.horizon-bcbsnj.com** or write to us at:

Horizon Blue Cross Blue Shield of New Jersey
NJ PLUS
P.O. Box 820
Newark, New Jersey 07101-0820

ACCESS TO QUALITY CARE

- **Ensuring network quality** - Helping our Members get to a healthier place starts with our physician network. By actively recruiting many of the area's top doctors, Oxford Members choose from one of the largest networks in the tri-state area. Here are some of the highlights:
  - — Oxford's providers meet state licensure and malpractice requirements.
  - — Our commercial network[1] includes over 50,000 credentialed physicians.
  - — PCPs can refer Members to thousands of specialists in our network.
  - — Providers are recredentialed every two years to ensure quality.
- **Complementary and alternative medicine program** - Members have access to the area's first credentialed network of Complementary and Alternative medical providers[2], including chiropractors, acupuncturists, massage therapists, yoga instructors, and nutritionists.
- **Fee-for-service** - Oxford pays doctors in our commercial network a fee for every covered service they provide, regardless of how many times a Member goes to the doctor's office.
- **Wide access to pharmacies** - Members with pharmacy benefits can fill their prescriptions at 12 home delivery pharmacies and a local network of more than 6,000 retail pharmacies, including all major pharmacy chains.
- **Access to most of the area's finest hospitals** - Including Saint Barnabas Medical Center, Valley Hospital, and Robert Wood Johnson University Hospital.
- **OB/GYN without a referral** - Women can choose an OB/GYN, whom they can see in addition to their PCP, without a referral.

LIVING A BALANCED LIFE

Oxford was the first major health plan to offer a Complementary and Alternative Medicine (CAM) Program with a credentialed network of providers. Today, Members have access to more than 2,400 complementary and alternative medicine providers.

Members can access Oxford's alternative medicine network in two ways:

- **Contracted Rate** - Oxford has negotiated contracted rates with all of the CAM providers in our network. These rates vary by specialty and region, and in most instances reflect a discount from the provider's normal fee. You can simply select an Oxford participating CAM provider, schedule an appointment, and pay the Oxford-negotiated rate to the provider at the time of the visit. This is not an insured benefit, so there is no need for a primary care physician (PCP) referral or additional paperwork.
- **Standard In-Network Benefits** - Members whose plan includes standard benefits for chiropractic coverage can visit any chiropractor in Oxford's CAM network for medically necessary care. You will need a PCP referral and are responsible for a copayment at the time of the visit.

MAKING WELLNESS A PART OF YOUR LIFE

- **No copayments for selected in-network care** - Annual physicals, one well-woman exam every six months, routine pediatric care, and immunizations.
- **Prescription drug coverage** - Prescription drug coverage is provided to employees whose employer does not offer a separate prescription drug plan. Prescription drug coverage is also provided to retirees. A $5 generic copayment, a $10 preferred brand copayment, and a $20 brand name copayment apply at a retail pharmacy for up to a 30-day supply. A prescription mail-order program for certain maintenance medications is also available, with a $15 generic copayment, $30 preferred brand copayment, and a $60 non-preferred brand copayment for a 90-day supply.
- **Disease Management programs** - Proactive efforts to help Members manage chronic conditions, such as asthma or diabetes, through educational materials.
- ***Active Partner*® program** - Personal reminders that encourage Members to receive important preventive care, including mammograms and flu shots.
- ***Healthy Mother, Healthy Baby*®** - Oxford's maternity program, designed to help maintain the health and well-being of pregnant mothers and newborns.
- ***Healthy Bonus*SM program** - Discounts on Weight Watchers®, optical services (glasses, eye exams, contact lenses), fitness clubs, and spas.
- ***Healthy Mind, Healthy Body*® Magazine** - Oxford's Member magazine is a source of cutting-edge information on prevention, nutrition, and exercise.
- **Gym reimbursement** - To keep Members motivated to achieve their fitness goals, Oxford provides limited reimbursement towards fitness center membership fees.

INFORMATION WHEN, WHERE, AND HOW YOU WANT IT

- ***Oxford On-Call*®** - A 24-hour healthcare guidance phone line staffed by Oxford registered nurses who can guide Members to an appropriate source of care.
- **www.oxfordhealth.com** - Self-service available via our Web site: Members can search for providers, check benefits, order ID cards, request materials, access wellness resources, or take an online tour to test drive Oxford.
- **Commitment to serve** - We meet the needs of our customers. Group Services works to help groups administer their plans; Service Associates resolve Member and provider issues in a thorough, courteous, and timely manner.

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[1]As of 12/31/01. This data represents all participating providers in Oxford's Freedom network except ancillary providers. Dental and alternative medicine providers are included. Providers who are multiply boarded are counted multiple times. All data is based on primary practice identification information.

[2]Provider type varies by region.

Oxford Health Plans®

To learn more, call: 1-800-760-4566 or
Visit our Web site at: *www.oxfordhealth.com*

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work℠

Traditional Plan

The Traditional Plan is an indemnity plan administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). Under the plan, you have freedom of choice to seek medical treatment from any properly licensed provider, as defined by the plan, anywhere in the world. However, the plan only provides reimbursement of expenses for the diagnosis and treatment of illness and injury. The plan does not cover preventive treatment (with the exception of mammographies and Pap tests) such as immunizations, physical examinations, or well-care physician visits. The Traditional Plan has three components: basic benefits (hospitalization), extended basic benefits (medical-surgical/professional) and major medical benefits.

Basic Benefits

Basic benefits include inpatient covered services at an approved acute care hospital, skilled nursing facility, or detoxification facility; and outpatient covered services billed by an approved facility or home health care agency, birthing center, and same-day surgical center.

Extended Basic Benefits

Extended basic benefits, also known as medical-surgical or professional benefits are paid according to a fee schedule and cover certain charges billed by an eligible provider for services such as surgery, anesthesia, X-rays, laboratory tests, and inpatient medical care.

Major Medical Benefits

Major medical benefits provide coverage for eligible services such as physician charges, medical services, and other supplies not completely paid under the basic and extended basic portions of the Traditional Plan. Under major medical, there is annual deductible of $100 per employee and $200 ($100 per employee and $100 for one other covered family member) per family. Once the deductible has been met, the plan will pay 80 percent of either the remaining eligible charges or 80 percent of the reasonable and customary fee. After an individual has $2,000 in eligible major medical charges during a calendar year, the plan will pay 100 percent of eligible charges for the remainder of the calendar year. You are responsible for a 20 percent coinsurance (or $400 out-of-pocket per individual), plus any ineligible costs or charges that are denied as being above the reasonable and customary fee for a service within the area where it was provided. The lifetime benefit maximum, under the major medical portion of the Traditional Plan only, is $1,000,000 per individual. However, there is a limited automatic restoration feature whereby, at the start of each calendar year, any previously used amount of the lifetime maximum will be restored up to the lesser of $2,000 or the amount needed to completely restore the maximum.

Participating Traditional Plan Providers

Under the Traditional Plan, over 24,000 providers in NJ, NY, and PA participating with Horizon BCBSNJ, have agreed to accept the Horizon BCBSNJ allowance, and are precluded from billing above that amount. In addition, these providers have agreed to accept no payment at the time of service and to submit claims on your behalf to Horizon BCBSNJ. You are only responsible for your annual deductible and 20 percent coinsurance based upon the discounted fee for eligible services, thereby reducing your out-of-pocket cost. There are similar arrangements with providers throughout the country with other Blue Cross and Blue Shield plans.

Prescription Drug Coverage

Active Local Employees -

Without a separate Prescription Program

If you are an active employee and your employer does not offer a prescription drug plan, the Traditional Plan provides a discounted prescription drug reimbursement program through major

medical benefits. When you present your discount card to the pharmacist you are charged a reduced fee for your medication and your claim is electronically submitted to the carrier for payment. After deductibles are met the Traditional Plan will reimburse 80 percent of the prescription cost.

Prescription Drug Coverage - Retirees

Retail Pharmacy - up to 90-day supply copayment amounts

Supply	Generic	Preferred Brand	All Other Brands
01-30 days	$6	$11	$23
31-60 days	$12	$22	$46
61-90 days	$18	$33	$69

Mail Order - 90-day supply copayment amounts

Generic	Preferred Brand	All Other Brands
$6	$17	$28

Effective January 1, 2003 there is a $397 annual maximum in prescription drug copayments per person. Once a person has paid $397 in copayments in a calendar year, that person is no longer required to pay any drug copayments for the remainder of that year. Prescription drug copayments are not eligible for reimbursement and do not apply to the Traditional Plan deductible or co-insurance.

Health and Wellness Discount Programs

Horizon BCBSNJ has established relationships with several businesses to provide various discount programs. These programs include but are not limited to the following:

SmartEyes^{SM} - discounts on eyeglasses through Cole Vision outlets. Call 1-800-424-1155.

Vision Care Advantage - discounts on laser vision correction services through Davis Vision. Call 1-877-518-8748.

Health Club Memberships - discounts at New York Sports Clubs (1-800-301-1231) and National Fitnesss Network (1-800-811-5454).

To take advantage of these programs, simply present your Traditional Plan ID card at a participating business or mention that you are a Horizon BCBSNJ member when calling. For a complete listing and description of available discount programs go to: www.horizon-bcbsnj.com/discounts.

For Additional Information - call Traditional Plan Customer Service at 1-800-414-SHBP (7427) during our service hours of Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also access our interactive Web-Site at **www.horizon-bcbsnj.com** or write to us at:

Horizon Blue Cross Blue Shield of New Jersey
Traditional Plan
P.O. Box 1609
Newark, New Jersey 07101-1609

The following comparison charts provide an easy way to compare the various SHBP health plans by summarizing what benefits each plan provides for a specified service. Because the charts contain a lot of information, using the following helpful hints can make reading these charts easier.

If you are looking for how a specific service is covered - locate the service that you are inquiring about along the left-hand side of the chart. Follow horizontally across the chart to compare how that

COVERED EXPENSES

	PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL PLAN 1-800-414-7427	#001 - NJ PLUS		#019 - AETNA 1-800-309-2386 Retiree on Medicare 1-800-345-4432
			In-Network 1-800-414-7427	Out-of-Network 1-800-414-7427	
EXPENSES COVERED	SERVICE AREAS	Unrestricted	All of NJ, DE, NC & SC; Parts of NY & PA	Unrestricted	All of NJ, CT & DE; Parts of AZ, FL, IL, IN, MD, NY, NC, PA, TX & VA
	HOSPITAL INPATIENT	100% for up to 365 days; day 366+ at 80% after deductible	100%	70% after $200 per hospital stay deductible	100%
	SKILLED NURSING FACILITY	100% for up to 30 days per confinement	100% for up to 120 days per calendar year	70% for up to 60 days per calendar year	100%; unlimited number of days
	HOSPITAL PRE-ADMISSION TESTING	100%	100%	70% after deductible	100%
	PHYSICIAN (SURGERY)	Basic benefit at 100%; balance at 80% after deductible	100%	70% after deductible	100%
	PHYSICIAN (OFFICE VISITS)	80% after deductible no coverage for well-care	100% after $5 per visit copayment	70% after deductible, no coverage for well-care	100% after $5 per visit copayment
	CHIROPRACTIC	80% after deductible for up to 30 visits per calendar year	Up to 30 visits per calendar year; $5 per visit copayment; no PCP referral required	70% after deductible for up to 30 visits per calendar year	100% for up to 20 visits per year after $5 per visit copay-ment; PCP referral required
	EMERGENCY ROOM - ACCIDENT/ NON-ACCIDENT	100% for accidental injury; 80% for non-accidental injury after deductible	100% after $25 copayment if reported to PCP and/or NJ PLUS within 48 hours; copayment waived if admitted	100% after $25 copayment if reported to PCP and/or NJ PLUS within 48 hours; copayment waived if admitted. If not report-ed within 48 hours subject to deductible and coinsurance	100% after $35 copayment. Notice to PCP required within 48 hours, copayment waived if admitted

particular service is covered by the various health plans. Determine which plan provides the best coverage for the services that you or your family may need.

If you are looking for information about a specific plan offered by the SHBP - locate the plan name along the top row. The specific services offered by that plan are listed in the column under the plan name.

COVERED EXPENSES

#020 CIGNA HEALTHCARE 1-800-244-6224	**#028 OXFORD 1-800-760-4566**	**#033 AMERIHEALTH 1-800-877-9829**	**#034 HEALTH NET 1-800-441-5741**
All of NJ, CT, DE, PA, AZ, SC & Wash. DC; Parts of CA, FL, GA, MD, NY, NC, VA & WV	All of NJ; Parts of NY	All of NJ & DE; Parts of PA	All of NJ & CT; Parts of NY (Parts of PA pending approval)
100%	100%	100%	100%
100% for up to 120 days per calendar year	100% for up to 120 days per calendar year	100% for up to 180 days per calendar year	100% for up to 120 days per confinement
100%	100%	100%	100%
100%	100%	100%	100%
100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment
100% for up to 20 visits per year after $5 per visit copayment; PCP referral required	100% after $5 per visit copayment, no visit maximum; PCP referral required	100% for up to 20 visits per year, no copayment; PCP referral required	100% for up to 20 visits per year after $5 per visit copayment; no referral required
100% after $35 copayment. Notice to PCP required within 48 hours, copayment waived if admitted	100% after $25 copayment. Notice to PCP required within 48 hours, copayment waived if admitted	100% after $35 copayment. Notice to PCP required within 48 hours, copayment waived if admitted	100% after $25 copayment. Notice to PCP required within 48 hours, copayment waived if admitted

COVERED EXPENSES, *Continued*

	PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL PLAN 1-800-414-7427	#001 - NJ PLUS		#019 - AETNA 1-800-309-2386 Retiree on Medicare 1-800-345-4432
			In-Network 1-800-414-7427	Out-of-Network 1-800-414-7427	
EXPENSES COVERED	DURABLE MEDICAL EQUIPMENT	80% after deductible	90% reimbursement	70% after deductible	Special $100 copayment; then 100% for rest of year
	RADIATION/ CHEMOTHERAPY OUTPATIENT	80% after deductible	100%	70% after deductible	100% after $5 copayment per office visit
	HOSPICE	100%	100%	70% after deductible	100%
	IMMUNIZATIONS	Not covered	100% after $5 copayment per visit (except for travel)	70% for children under 12 months, after deductible	100% after $5 copayment per visit (except for travel)
	MATERNITY	Basic benefits at 100%; balance at 80% after deductible	$5 copayment for first prenatal office visit then 100% covered	70% after deductible	$5 copayment for first prenatal office visit then 100% covered
	PHYSICAL EXAMS	Not covered	100% after $5 per visit copayment	Not covered	100% after $5 per visit copayment
	WELL BABY	Not covered	100% after $5 per visit copayment	Not covered	100% after $5 per visit copayment
	ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence
	DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence
	ALCOHOL ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% for up to 60 visits per calendar year
	DRUG ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% for up to 60 visits per calendar year

COVERED EXPENSES, *Continued*

#020 CIGNA HEALTHCARE 1-800-244-6224	#028 OXFORD 1-800-760-4566	#033 AMERIHEALTH 1-800-877-9829	#034 HEALTH NET 1-800-441-5741
Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year
100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit
100%	100%	100%	100%
100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)
$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered
100% after $5 per visit copayment (1 visit per calendar year)	100%	100% after $5 per visit copayment	100% after $5 per visit copayment
100% after $5 per visit copayment	100%	100% after $5 per visit copayment	100% after $5 per visit copayment
100% detox; rehab - 30 days at 100% per occurrence	100% detox and rehab	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence
100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence
100% for up to 60 visits per calendar year	100% for up to 60 visits per calendar year	100% for up to 60 visits per calendar year	100% for up to 60 visits per calendar year
100% for up to 60 visits per calendar year	100% for up to 60 visits per calendar year	100% for up to 60 visits per calendar year	100% for up to 60 visits per calendar year

COVERED EXPENSES, *Continued*

	PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL PLAN 1-800-414-7427	#001 - NJ PLUS		#019 - AETNA 1-800-309-2386 Retiree on Medicare 1-800-345-4432
			In-Network 1-800-414-7427	Out-of-Network 1-800-414-7427	
EXPENSES COVERED	**MENTAL[1] HEALTH (INPATIENT)**	100% for 20 days per calendar year; balance at 80% after deductible up to annual/lifetime maximums	100% for up to 25 days per calendar year; balance at 90% up to annual/lifetime maximums	50 days per calendar year at 50% after deductible up to annual/lifetime maximums	100% for up to 35 days per calendar year
EXPENSES COVERED	**MENTAL[1] HEALTH (OUTPATIENT)**	80% after deductible up to $10,000 annual/ $20,000 lifetime maximum	90% up to $15,000 annual/$50,000 lifetime maximum	70% after deductible up to $15,000 annual/$50,000 lifetime maximum	100% after $10 copayment per visit for up to 30 visits per calendar year
EXPENSES COVERED	**PHYSICAL / SPEECH THERAPY[2]**	80% after deductible (Other plan provisions may apply)	100% after $5 per visit copayment	70% after deductible	100% after $5 copayment per visit, 60 visits per condition per year
EXPENSES COVERED	**DENTAL COVERAGE**	None	None	None	None
EXPENSES COVERED	**X-RAYS / LAB TESTS**	80% after deductible; some charges paid at 100%	100% after $5 copayment per visit	70% after deductible	100% after $5 copayment per visit
EXPENSES COVERED	**PRESCRIPTION DRUGS[3]** Benefits for ***ACTIVE*** employees without an employer provided drug plan.	80% after deductible	90% reimbursement	70% after deductible	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25
EXPENSES COVERED	**PRESCRIPTION DRUGS[3]** ***RETIREE***	Pharmacy: 30-day supply Generic - copayment $6 Preferred brand - $11 Other brands - $23 Mail Order: 90-day supply Generic - $6 Preferred brand - $17 Other brands - $28 $397 Maximum copayment per member per year.	Pharmacy: 30-day supply Generic - copayment $6 Preferred brand - $11 Other brands - $23 Mail Order: 90-day supply Generic - $6 Preferred brand - $17 Other brands - $28 $397 Maximum copayment per member per year.	Pharmacy: 30-day supply Generic - copayment $6 Preferred brand - $11 Other brands - $23 Mail Order: 90-day supply Generic - $6 Preferred brand - $17 Other brands - $28 $397 Maximum copayment per member per year.	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25
EXPENSES COVERED	**ROUTINE VISION EXAM**	None	100% after $5 copayment; one exam per calendar year; no referral needed	None	100% after $5 copayment; one exam every 2 years; no referral needed

[1]Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visits.

COVERED EXPENSES, *Continued*

#020 CIGNA HEALTHCARE 1-800-244-6224	#028 OXFORD 1-800-760-4566	#033 AMERIHEALTH 1-800-877-9829	#034 HEALTH NET 1-800-441-5741
100% for up to 30 days per calendar year	100% for up to 30 days per calendar year	100% for up to 30 days per calendar year	100% for up to 30 days per calendar year
100% after $5 copayment per visit for up to 30 visits per year	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $5 copayment per visit for up to 30 visits per calendar year
100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year
None	Exams and cleaning for members under age 12	Exams, cleaning, and fluoride treatments for members under age 12	None
100%	100%	100%	100%
Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $15 Name brand - $30	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25
Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $15 Name brand - $30	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 Mail Order: 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25
100% after $5 copayment; one exam per calendar year; referral needed	$50 reimbursed toward routine exam per 12 month period	100% after $5 copayment; one exam every 24 month period; must use specified vendor; no referral needed	100% after $5 copayment; one exam per calendar year; no referral needed

[2] Speech therapy limited to: restoration after a loss or impairment of a demonstrated previous ability to speak; develop or improve speech after surgical correction of a birth defect.
[3]Certain prescription drugs may require precertification prior to purchase.

HMO PLAN STANDARDS

The SHBP has established minimum coverage requirements and operating standards for all participating HMOs that safeguard our members and make it easier to compare and choose between plans. The following is not a benefit summary but a listing of benefit coverage for which the SHBP has imposed a mandatory expectation or requirement.

Standards Include:

— All physician referrals will be valid for a minimum of 90 days from the date of authorization.

— Certain treatments requiring numerous visits (e.g., chemotherapy) shall not require repeated referrals.

— Member packets must include a Schedule of Benefits which will provide a list of covered services, benefit limitations and benefit exclusions, and appropriate definitions.

— The HMO will notify the State and members prior to any proposed changes in the provider network, including facilities, that alter member access to providers or services.

— There shall be no pre-existing condition restrictions.

— Network within network referral restrictions will not be permitted.

— Right to change Primary Care Providers must be permitted on at least a monthly basis.

— Scope of services covered under the well-woman OB/GYN provisions must be clearly defined, including the explicit services which must be authorized by the member's PCP. It is required that two or more well-woman OB/GYN examinations be available during the Benefit Plan Year, and that a well-woman mammogram not require a PCP authorization.

— HMO members must be permitted to self-refer to network mental health and substance abuse practitioners.

— Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need not require hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:

- the date the total disability ends;
- one year from the date the person's coverage under the SHBP ends;
- the date the person has received the maximum benefits under the HMO's Plan for the disabling condition; or

- the person becomes covered under any replacement plan established by the employer.

Emergency

— The following definition for emergency care will be adhered to by all plans:

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) serious impairment to bodily function; or

c) serious dysfunction of any bodily organ or part.

— There will be a $35 maximum copayment for emergency room services; waived if admitted.

— With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the Health Maintenance Organization. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by the Health Maintenance Organization.

Minimum Coverage Requirements

Benefit standards include:

— Routine office visit copayments will be $5.

— All plans will cover chiropractor visits up to a maximum of 20.

— $100 will be the maximum annual copayment for medical appliances and durable medical equipment.

— Hair prosthesis furnished in connection with hair loss resulting from the treatment of disease by radiation or chemicals will be covered.

— Routine inoculations for adults (not related to travel or occupation) will be covered.

— The cost of care to organ transplant donors will be covered. (Coordination of benefits will apply.)

— Admissions at skilled nursing homes will be covered up to 120 days.

— Hospice services will be covered in full.

— Home health care will be covered up to a minimum of 120 visits.

— Outpatient therapy will be covered up to 60 visits per condition.

— Repair and replacement of prosthesis will be covered.

— Surgical leggings, ostomy supplies, and foot orthotics will be covered if medically necessary.

— There will be no reimbursement for vision hardware.

Mental Health and Alcohol/Substance Abuse

— There will be no copayment charged for outpatient drug and alcohol rehabilitation treatment.

— All plans will use standard treatment criteria established by the American Society of Addictive Medicine (ASAM).

— Following a detoxification patients are entitled to 28 days of inpatient rehabilitation per occurrence.

— Biologically-based mental heath conditions are treated like any other illness.

AUTOMOBILE-RELATED INJURIES

The SHBP will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your SHBP plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your health plan, then the SHBP will automatically be primary to your PIP policy. If you elect your SHBP plan as primary, this election may affect each of your family members differently.

When the SHBP is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the SHBP health plan you have chosen. For example, if you are enrolled in an HMO you would need referrals from your Primary Care Physician, precertifications, preauthorizations, etc., just as you would for any other treatment to be covered. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your SHBP plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

If your SHBP plan is secondary to the PIP policy, the actual benefits payable will be the lesser of:

— the remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other applicable provisions of your SHBP plan, after application of any applicable deductibles and coinsurance; or

— the actual benefits that would have been payable had your SHBP plan been primary to your PIP policy.

If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your plan's handbook and your PIP policy to assist you in making this decision.

STATE HEALTH BENEFITS PROGRAM INFORMATION

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to contracts, etc. must be presented through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

To be eligible for State employee coverage, you must work full-time or be an appointed or an elected officer of the State of New Jersey. For State employees, full-time normally requires 35 hours per week.

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary. Each employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year.

Eligible Dependents

Your eligible dependents are your spouse and/or your unmarried children under age 23 who live with you in a regular parent-child relationship. This includes children who are away at school as well as divorced children living at home and dependent upon you for support. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children — *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases. If a Qualified Medical Child Support Order (QMCSO) is issued for your child, the health plan of the parent named in the QMCSO will be the primary plan for that child. The employer must be notified of the QMCSO and a *NJ State Health Benefits Program Application* submitted electing coverage for the child within 60-days of the date the order was issued.

Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases.

Coverage for an enrolled child will end when the child marries, moves out of the household, or turns age 23. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the COBRA section on page 48 for continuation of coverage provisions).

If a child is not capable of self-support when (s)he reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued. To request continued coverage, call or write the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, and (2) the child continues to

be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Enrollment

You are not covered until you enroll in the SHBP. You must fill out a *NJ State Health Benefits Program Application* and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so (see exceptions below). Open Enrollment periods generally occur once a year. Information concerning the duration of the Open Enrollment period and effective dates of coverage are announced by the Division of Pensions and Benefits.

Dual HMO Enrollment is Prohibited

State statute specifically prohibits two members who are married to each other and who are **both** enrolled in the SHBP from enrolling under any **two** of the SHBP's HMO plans. One member may belong to a SHBP HMO as an employee or as a dependent but not as both.

For example, if two SHBP members are married to each other, each may elect to enroll for single coverage under any of the HMO plans, or one member can enroll the other as a dependent under a SHBP HMO if the other person has the Traditional Plan or NJ PLUS coverage.

Furthermore, two SHBP members cannot both cover the same children as dependents under any two SHBP HMO plans.

In cases of divorce or single parent coverage of dependents, there is **no coordination of benefits** under two HMO plans or double coverage under NJ PLUS.

Change of Coverage

To change your coverage you should contact your benefits administrator or human resource representative and complete a *NJ State Health Benefits Program Application*. You are eligible to change your coverage under the following circumstances.

- You marry and want to enroll your spouse and newly eligible dependent children. You must file a new *NJ State Health Benefits Program Application* within 60 days of the marriage.
- You need to enroll a new child. You must file a new *NJ State Health Benefits Program Application* within 60 days after birth or adoption and submit legal documentation.
- You have a change in family status involving the loss of eligibility of a family member (divorce, death, child marries, no longer lives with you, or turns 23).
- You move out of a plan's service area. You can change plans immediately; however, if you do not change within 30 days of the move, you must wait until the next Annual Open Enrollment period.
- You are going on a leave of absence and cannot afford to pay for coverage. You can reduce your coverage, for example, from family to parent and child when you go on leave and increase it back to family upon your return to work.

— Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage. You have 60 days from the date of the event to make adjustments to your coverage that are necessary to compensate for the loss of this coverage. A copy of your spouse's and or dependent's Certificate of Continued Coverage must be submitted with the *NJ State Health Benefits Program Application*.

— Your child, under the age of 23, has divorced and moves back into your household, and is dependent upon you for support and maintenance. You must file a *NJ State Health Benefits Program Application* within 60 days after the child has returned home, with a copy of the child's divorce decree, if you wish to enroll this child under your coverage.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your SHBP health benefits coverage begins, provided you submit a completed *NJ State Health Benefits Program Application*. Your enrolled eligible dependent's coverage is effective the same date as yours provided you have paid any required contribution.

Coverage for State biweekly employees begins on the first day of your fifth payroll period. The exact date of your coverage will be determined by the State's centralized payroll date schedule. Contact your benefits administrator or human resource representative if you need to know the exact date of coverage.

If you are a local government or local education employee or a State monthly employee, your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following *exceptions* apply to this effective date of coverage.

— If you have at least two months of service on the date your employer joins the SHBP, your coverage starts on the date your employer enters the program.

— If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1.

— If you were enrolled in the SHBP with your previous employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, birth, adoption, etc.) providing the application is filed within 60 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau. Dependent children are automatically terminated as of the end of the year they attain age 23 and do not require the completion of an application to decrease coverage.

Transfer of Employment

If you transfer from one SHBP-eligible employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that you:

— are still covered by the SHBP (COBRA coverage excluded) when you begin in

your new position; or

- transfer from one participating employer to another; **and**
- file a new *NJ State Health Benefits Program Application* listing the former employer in the appropriate section of the application.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness.
- Approved leave of absence other than illness.
- Family Leave Act (federal and state).
- Furlough.
- Workers' Compensation.
- Suspension (COBRA continuation only).

When you take an approved leave of absence, you may reduce your coverage (for financial reasons) and increase it again when you return from leave. When you return to work, your benefits and those of your eligible family members are reinstated upon completion of a *NJ State Health Benefits Program Application.* Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence. When the leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of COBRA.

Family and Medical Leave Act

State and local employees participating in the SHBP are entitled to have their coverage continued at the expense of their employer while they are on family leave. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any. To qualify for the federal Family and Medical Leave Act of 1993 (FMLA), you must have a personal illness, a newborn child, or need to care for an ill family member, and be employed for 12 months. The FMLA defines the family member as a spouse, parent, or child. The FMLA provides up to 12 weeks in a 12-month period.

To qualify for the New Jersey Family Leave Act (NJFLA), you must have a need to care for an ill family member or a newborn child. There is no provision for an employee's own personal illness. The NJFLA provides up to 12 weeks in a 24-month period.

If an employee takes a leave for the care of a family member, both the FMLA and the NJFLA will run concurrently. If an employee takes a leave for maternity, they are on the FMLA. After their doctor releases them from their maternity leave, they can take the NJFLA for the care of the newborn child. This then provides the parent with up to 24 weeks of employer paid benefits.

Furlough

If you take an approved furlough, your SHBP coverage will continue at the employer's expense. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any.

Effective April 30, 2002 the Department of Personnel Merit System Board issued a "rule relaxation" extending through June 30, 2003. During this period, a State employee can take unlimited furlough, if approved by their employer, without loss of employer paid health benefits.

As of July 1, 2003 the "rule relaxation" will cease and health benefits will only be covered for up to 30 days of furlough. Extensions beyond the normal 30 days allowed will be treated as an exceptional case. You will have to pay for the full cost of coverage for your extended furlough days in 10-day increments or drop your coverage for the entire benefit period(s) in which you take a furlough day.

End of Coverage

Coverage for you and your dependents will end if:

- you voluntarily terminate coverage;
- your employment terminates;
- your hours are reduced so you no longer qualify for coverage;
- you take a leave of absence and do not make required premium payments;
- you enter the Armed Forces and are eligible for government-sponsored health services;
- your employer ceases to participate in the SHBP; or
- the SHBP is discontinued.

Coverage for your dependents will end if:

- your coverage ceases for any of the reasons listed above;
- you die (dependent coverage terminates the 1st day of the pay period following the date of death for dependents of State employees paid through the State'sCentralized Payroll Unit, or the 1st of the month following the date of death for dependents of all other employees) ;
- your dependent is no longer eligible for coverage (divorce of a spouse; children marry, move out of the household, or turn age 23 unless the dependent child qualifies for continuance of coverage due to disability (see page 37);
- your payment for coverage is not made when due; or
- your enrolled dependent enters the Armed Forces.

Return from Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you complete a *NJ State Health Benefits Program Application*. **You must complete this application within 60 days after you return to work.** Coverage becomes effective on the date you return to work if you are a State monthly or local employee or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage upon your

return to work.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make Open Enrollment types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you purchased COBRA coverage while on leave, you must file a new *NJ State Health Benefits Program Application* **within 60 days** of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

Workers' Compensation

If you have a Workers' Compensation award pending or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same contribution level as when you were an active employee. You must remit to your employer, in advance, that portion or the premiums that you would normally pay, if any.

Medicare Parts A and B

It is not necessary for a Medicare-eligible employee or spouse to be covered by Medicare while they remain actively at work. It is required that they enroll in both Parts A and B prior to retirement so that coverage will be effective at the time of retirement.

RETIREE COVERAGE

Retiree Eligibility

The following individuals, who are covered by, or eligible for, employer-provided health insurance coverage **until their retirement date**, will be offered State Health Benefits Program (SHBP) coverage for themselves and their eligible dependents when they retire:

- State employees, employees of state universities/colleges and autonomous state agencies and commissions, as well as local employees who were covered by the SHBP.
- Members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with 25 years or more of service credit in the pension fund or who retire on a disability retirement, even if their employer did not cover its employees under the SHBP. This includes those who elect to defer retirement with 25 or more years of service credit in the pension fund.
- Members of the TPAF and PERS who ***retired*** from a board of education, vocational/technical school, or special services commission, if they are participating in the health benefits plan of their former employer and are enrolled in Medicare Parts A and B. A qualified retiree may enroll at the time of retirement or when becoming eligible for Medicare.

— Participants in the Alternate Benefit Program (ABP) who retire with at least 25 years of credited ABP service or those who are on a long-term disability.

— Certain local policemen or firemen with 25 years or more of service credit in the pension fund or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when becoming eligible for Medicare.

The SHBP is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in the SHBP's Retired Group coverage. Early filing is recommended to prevent any lapse of coverage or delay of eligibility.

Eligibility for membership in the SHBP for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and

2. You were eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment).

This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment, you will lose your eligibility for health coverage under the Retired Group of the SHBP. (This does not include TPAF retirees and PERS board of education or county college retirees with 25 or more years of service). However, if you continue group coverage through COBRA until your retirement becomes effective or as a dependent of another employee participating in the SHBP, you will be eligible for retired SHBP coverage. An explanation of SHBP COBRA coverage begins on page 48 of this book.

Medicare Coverage

IMPORTANT: A Retired Group member and/or dependent spouse who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP Retired Group coverage.

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 777-1450. If you do not submit evidence of Medicare coverage under both Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the SHBP.

IMPORTANT: If a provider does not participate with Medicare, no benefits are payable

under the SHBP for the provider's services.

A Member May be Eligible for Medicare for the Following Reasons:

— ***Medicare Eligibility by Reason of Age***

This applies to a member who is the employee or covered spouse and is at least 65 years of age.

A member is considered to be eligible for Medicare by reason of age from the first day of the month during which (s)he reaches age 65. However, if (s)he is born on the first day of a month, (s)he is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reason of Disability***

This applies to a member who is under age 65.

A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reasons of End Stage Renal Disease***

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The above rules, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

As of 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the MEDICARE eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of benefits period

During the "coordination of benefits" period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is primary

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary.

— ***Dual Medicare Eligibility***

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then the group health plan continues to be primary to 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then the health plan continues to be the secondary payer. There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

— You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."

— The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.

— After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.

— If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to (name of your SHBP plan) for their consideration in processing supplementary coverage benefits."

— If the above statement does not appear on the *Explanation of Benefits,* you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form of your SHBP plan.

Out-Of-State Physicians or Providers:

— The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social

Security office for information.

— When you receive the *Explanation of Benefits,* indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 37) except for the Medicare requirements as stated above.

Change of Coverage

To change your coverage you should contact the Office of Client Services at the Division of Pensions and Benefits and request a *SHBP Retired Status Application.* You are eligible to change and should change your coverage under the following circumstances.

— You marry and want to enroll your spouse.

— You need to enroll a new child.

— You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives at home, or turns age 23).

— You wish to change your medical plan. A Retired Group member can switch medical plans once in any 12-month period or when rates change.

— You move out of the plan's service area. The 12-month change rule mentioned above is waived in cases like this.

— Your spouse's employment status changes resulting in a significant change in health coverage.

IMPORTANT: Retirees should immediately notify the Health Benefits Bureau of changes in family status. (1) Deleting coverage for dependents may affect premium rates and, although claims for ineligible dependents cannot legally be paid, *premiums cannot be reduced until appropriate notification is provided to the Health Benefits Bureau*. (2) Failure to submit a *SHBP Retired Status Application* to remove from your coverage a deceased or ineligible spouse for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

SPECIAL RETIRED GROUP RULES

Limitations on Enrolling Dependents and Changing Coverage

Eligible dependents can be added to Retired Group coverage upon initial enrollment of the retiree and within 60 days of a change of family status (marriage, birth of child, etc.) that made the dependent eligible. The family member will be enrolled retroactive to the date of eligibility.

If the application to add a spouse or dependent is not received within 60 days of the status change, there will be a minimum 2 month waiting period from the date the enrollment application is received until the member is covered — beginning the first of the month following the expiration of the waiting period. You may remove family members from coverage at any time.

Decreases in coverage will be processed on a timely basis. **It is your responsibility to notify the SHBP of any change in family status.** If family members are not properly enrolled, claims will not be paid.

Dual HMO Enrollment is Prohibited

State statute specifically prohibits two members who are married to each other and who are **both** enrolled in the SHBP from enrolling under any **two** of the SHBP's HMO plans. One member may belong to a SHBP HMO as an employee/retiree or as a dependent but not as both.

For example, if two SHBP members are married to each other, each may elect to enroll for single coverage under any of the HMO plans, or one member can enroll the other as a dependent under a SHBP HMO if the other person has the Traditional Plan or NJ PLUS coverage.

Furthermore, two SHBP members cannot both cover the same children as dependents under any two SHBP HMO plans.

In cases of divorce or single parent coverage of dependents, there is **no coordination of benefits** under two HMO plans or double coverage under NJ PLUS.

Effective Dates

The effective date of any change in which a dependent is added to coverage because of **marriage, birth, or adoption** is retroactive to the date the event occurred if the *Retired Status Application* is filed within 60 days of the event (marriage, birth, adoption, etc.) with the SHBP. If the *Retired Status Application* is not received within 60 days of the event by the SHBP, the effective date will be the first of the month following a full two-month waiting period from the date of receipt of the application.

You are responsible for notifying the Health Benefits Bureau of a coverage change due to **death or divorce**. The effective date is the first day of the month following the date of death or divorce. Any claims incurred or services provided after this date are ineligible for payment.

The effective date of **any other change or termination of coverage** is based on the billing cycle in which the change or termination is received. In most cases, if an application for a change is received before, for example, January 15, the effective date will be February 1. If the application is received after January 15, the effective date will be March 1. The effective date of any transaction may be delayed if the member fails to submit the appropriate application and supporting information on a timely basis.

End of Coverage

Your coverage under the Retired Group terminates if:

- you formally request termination in writing, or by completing a *SHBP Retired Status Application;*
- your retirement is canceled;
- your pension allowance is suspended;
- you do not pay your required premiums;
- your plan discontinues services in your area and you do not submit an application to the SHBP to change to another plan;

— you or your spouse do not provide proof of enrollment in Medicare Parts A and B when eligible for Medicare coverage;

— your former employer withdraws from the SHBP (this may not apply to certain retirees of education, police, and fire employers);

— your Medicare coverage ends;

— you die (dependent coverage terminates the 1st of the month following the date of death); or

— the SHBP is discontinued.

Once coverage is terminated you may not be permitted to be reinstated.

Survivor Coverage

If you, the retired member, predecease your covered spouse and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage in the SHBP. Surviving dependents are generally notified of their rights to continued coverage at the time the Division of Pensions and Benefits is notified of the death of the retiree; however, they may contact the Division of Pensions and Benefits' Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the Division of Pensions and Benefits as soon as possible after your death because their dependent coverage ends on the first of the month after the date of your death.

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see Duration of Coverage, on page 49), and the member must pay the full cost of the coverage plus an administrative fee. The member/dependent can increase his or her level of coverage, i.e., add dependents or elect coverage (s)he did not have as a member/dependent.

Leave taken under the federal and/or State Family Leave Act is no longer subtracted from your COBRA eligibility period.

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP medical coverage and, if offered by your employer, State prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the SHBP Open Enrollment period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission makes changes to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- — Termination of employment (except for gross misconduct).
- — Death of the member.
- — Reduction in work hours.
- — Leave of absence.
- — Divorce or legal separation (makes spouse ineligible for further coverage).
- — Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, or marriage.
- — The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if (s)he becomes eligible because of your **death or divorce**, or (s)he becomes ineligible for continued group coverage because of **marriage, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage.**

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- — notify you and your dependents of the COBRA provisions when you and your

dependents are first enrolled;

— notify you, your spouse, and your children of the right to purchase continued coverage when they become aware of a COBRA event that causes a loss of coverage;

— send the *COBRA Notification Letter* and a *COBRA Application* within 14 calendar days of receiving notice that a qualifying event has occurred; and

— maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

— notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, or death has occurred or that your child has married, moved out of your household, or reached age 23 - notification must be given within 60 days of the date the event occurred;

— file a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;

— pay the required monthly premiums in a timely manner; and

— pay premiums, when billed, retroactive to the date of group coverage termination.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

— your eligibility period expires;

— you fail to pay your premiums in a timely manner;

— after the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);

— you voluntarily cancel your coverage;

— your employer drops out of the SHBP;

— you become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans, which cover mastectomies, must cover breast reconstruction; surgery to produce a symmetrical appearance; prostheses; and treatment of any physical complications.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-fed-

eral government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Mental Health Parity Act Requirements

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Centers for Medicare and Medicaid Services for calendar year 2002 and is expected to file an exemption for calendar year 2003. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS will not change, with an exception for *biologically-based* mental illness. Maximum annual and lifetime dollar limits for mental health benefits are outlined in the comparison charts (beginning on page 28).

All SHBP health plans meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* (COC) form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resource office, should you terminate your coverage.

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a converted policy, New Jersey residents who are not Medicare eligible, should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at *www.njdobi.org*

If you are Medicare eligible you may qualify for a Medigap policy through the New Jersey Department of Health and Senior Services — State Health Insurance Program (SHIP). For more information, contact SHIP at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to conversion.

EXTENSION OF BENEFITS

If you are disabled with a condition or illness at the time of your termination from the SHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this condition or illness. If you feel that you may qualify for an extension of benefits please contact your claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any SHBP plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which the person ceases to be a covered person. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals might question eligibility or plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- employee's identification number;
- date(s) of service(s);
- provider's name and identification number;
- the specific remedy being sought; and
- the reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299

Notification of all Commission decisions will be made in writing to the member. If the Commission approves the member's appeal, the decision is binding upon the health plan. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days in writing to the Commission, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is

rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination from coverage of dependents.

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